STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPI	LETED
		155468	B. WIN			05/05/2	2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	ME OF PROVIDER OR SUPPLIER				EST NORTHWOOD DR		
BRECKE	NRIDGE HEALTH	& REHABILITATION		1	/AN, IN47882		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
•	This visit was	for the Investigation	F0	000	Submission of this plan of		
		•			correction does not constitut	е	
	of Complaints IN00088658 and IN00089737. Complaint IN00088658 - Substantiated. Federal/state				admission or agreement by	the	
					provider of the truth of facts		
					alleged or correction set fort	ποπ	
					the statement of deficiencies. This plan of		
					correction is prepared and		
					submitted because of		
	deficiencies re	elated to the			requirement under state and		
	allegations are	e cited at F282 and			federal law. Please accept the plan of correction as our cre		
	F333.				allegation of compliance.Ple		
					find enclosed the plan of	asc	
	G 1: DY	00000505			correction for the survey end	ling	
	Complaint IN				May 5, 2011.Due to the low	scope	
	Unsubstantiate	ed due to lack of			and severity of the survey		
	evidence.				findings, please also find enclosed sufficient		
					documentation providing		
	Survey date: 1	May 05, 2011			evidence of compliance with plan of correction. The documentation serves to cor		
	Facility number	er: 000525			the facility's allegation of		
	Provider numb				compliance. Thus, the facility		
					respectfully requests the gra of paper compliance. Should		
	AIM number:	10026/010			additional information be	ı	
					necessary to confirm said		
	Survey team: Kimberly Perigo, RN				compliance, feel free to cont me. Respectfully,Lori	act	
					Lewis-WhiteAdministrator		
	Census bed ty	pe:					
	SNF/NF: 39						
	Residential: 0)1					
	Total: 40						
	10001. 10						
			1		I		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JH4N11

Facility ID:

000525

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155468			(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/05/2	ETED
	PROVIDER OR SUPPLIER	& REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 325 WEST NORTHWOOD DR SULLIVAN, IN47882				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	findings cited 410 IAC 16.2.	cies also reflect state in accordance with completed 5/10/11					
F0282 SS=D	facility must be proin accordance with plan of care. Based on reconsinterview, the ensure 1 of 3 reservices provide with the writter received medications not been administed.	facility failed to esidents reviewed for ded in accordance n plan of care cations as prescribed	F02	82	The facility will ensure this requirement is met through the following corrective measure Resident A was returned back the facility with no negative outcome.2. All residents have potential to be affected. QM was disciplined according to facility's progressive discipline process and re-educated on facility's medication administration policy.3. The facility's medication administration policy was	s:1. kk to e the A #1 the	05/22/2011

PRINTED: FORM APPROVED OMB NO. 0938-0391

05/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155468 05/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 325 WEST NORTHWOOD DR BRECKENRIDGE HEALTH & REHABILITATION SULLIVAN, IN47882 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE reviewed and no changes are indicated at this time (see Findings include: attachment). Licensed nurses and QMA's were re-educated on the policy. The DON or her The facility's Medication designee will randomly observe Administration Policy and medication administration 3 times weekly for 4 weeks, then once Procedure, dated September 2005, weekly for 4 weeks, then once a was provided by the Director of month for 2 months, then quarterly thereafter (see Nursing on May 05, 2011, and attachment).4. The findings of indicated, "PURPOSE: To these audits will be reviewed during the facility's quarterly administer medications according Quality Assurance meetings and to the guidelines set forth by the the plan of action adjusted State and Federal regulations." accordingly.5. The above corrective measures will be completed on or before May 22, The Nursing Spectrum Drug 2011. Handbook, dated 2010, indicated the importance of following the prescriber's medication orders by implementation of "The 'five rights' of drug administration: Nurses are legally responsible for applying and ensuring the 'five rights' of drug administration....Right patient. Right drug. Right dosage. Right time. Right route." The Qualified Medication Aide [Q.M.A.] Basic Curriculum, dated October 2003 [most current], indicated the Q.M.A. is responsible

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155468	A. BUII	LDING	00	COMPLETED 05/05/2011	
		155406	B. WIN			05/05/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EST NORTHWOOD DR		
BRECKE	NRIDGE HEALTH	& REHABILITATION		1	/AN, IN47882		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(5)
PREFIX TAG	(EACH DEFICIEN REGULATORY OR		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TE COMPL		
	to administer r						
	prescribed by	the physician by					
	following; "Pr	inciples of					
	Administering	MedicationsSix					
	Rights of Med	ication					
	1 -	n: A. Give the					
	RIGHT MEDI	CATION. B. Give					
	the RIGHT DO	OSE. C. Give the					
	medication to	the RIGHT					
	RESIDENT.						
		the RIGHT ROUTE.					
	1	edication at the					
		. F. Enter the RIGHT					
		ATION in the chart."					
	DOCOMENT	ATTOW III the chart.					
	Resident A's c	linical record was					
	reviewed on M	May 05, 2011, at 10:45					
	a.m.						
	Licensed Nurs	e #1's Nurse's Notes,					
	dated March 2	5, 2011, at 9:18 a.m.,					
		Licensed Nurse #2,					
	indicated; "QMA reported to 100						
	hall chg [charge] nurse [Licensed						
	Nurse #1] that she gave another						
	Resident's medication to this						
	Resident [Resident A]. Res.						
	[Resident A] rec'd [received]						
	1	i [one], ASA 81 mg i					
	1 tor vase 3 mg	i [ono], mon or mg i					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155468	B. WIN			05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BRECKE	NRIDGE HEALTH	& REHABILITATION		1	AN, IN47882		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	[one], Lexapro	20 mg i [one],					
	Metoprolol 50	mg i [one],					
	Risperidal 0.2:	5 mg i [one],					
	Benadryl 25 m	ng i [one], Lorazepam					
	1 mg i [one], N	Metformin 500 i [one]					
	et [and] K-dur	10 meq ii [two] tabs					
	@ this X [time	e]; meds					
	[medications]	weren't this					
	l -	sident A] meds to rec					
	[receive]."						
	Dhygigian's ord	Jors for March 2011					
	· ·	ders for March 2011 entation to indicate					
		nad ordered the					
	medications.	iau orucicu iiic					
	medications.						
ı	Interview of L	icensed Nurse #1 on					
	May 05, 2011,	at 1:25 p.m.,					
	Licensed Nurs	e #2 on May 05,					
		o.m., and the Director					
	of Nursing on	May 05, 2011, at					
	2:30 p.m., indi	cated on March 25,					
	2011, during the morning						
	medication pas						
		dication Aide] #1 had					
	reported giving						
		at had not been					
	_	her. The medications					
	had been set u	p for another resident					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155468		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/05/2	LETED	
	NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION			STREET A	ADDRESS, CITY, STATE, ZIP CODE EST NORTHWOOD DR AN, IN47882		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	and given to R	esident A by mistake.					
		ns given were those					
	1	the Nurses Notes 5, 2011, at 9:18 a.m.					
	Q.M.A. #1 wa During the into indicated during medication pass residents' med she had gotten mixed up. Q.M. Resident A and medications, in prescribed for given in error documented in	erview Q.M.A. #1 ng the morning ss she had two ications set up and the medications M.A. #1 had given other resident's nedications not her. The medications					
	March 25, 201	Nurses Notes, dated 1, indicated she had local acute care aluation.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155468			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 05/05/2	LETED
	PROVIDER OR SUPPLIER	& REHABILITATION	325 WE	ADDRESS, CITY, STATE, ZIP CODE EST NORTHWOOD DR /AN, IN47882	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	nursing home apparently give medications for further more management 91 year old we impression: 1 post administre medications (repatient). 3) De 5) History of he Dizziness 7) A Diabetes mellipatient is administre monitoring and Will continue as well as neurolosely. 3) Will monitor for an EKG changes.	She is a resident of a where she was en the wrong. She was admitted nitoring and ASSESSMENT: A oman with) Lethargy 2) Status ation of multiple not intended for the chydration 4) Anemia hypertension 6) atrial fibrillation 8) tus. PLAN: 1) The fitted for further d management. 2) to monitor her vitals rological status all also continue to y electrolytes and	TAG	DEFICIENCY)		DATE

	OF OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468	A. BUI	LDING	onstruction 00	(X3) DATE COMPL 05/05/2	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST NORTHWOOD DR AN, IN47882		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0333 SS=D	free of any signific Based on reconsinterview, the ensure 1 of 1 rasignificant management of the significant management of the significant management of the sample of 6. [Indings inclusted the sample of 6. Indings inclusion of the sample of 6. Indianate of 6. Indi	facility failed to esident reviewed for redication error was eant error, in that I medications were to the resident, in a Resident A] de: Medication In Policy and It indicated, It indicated, It indicated, It indicated, It is	FO	3333	The facility will ensure this requirement is met through the following corrective measures. Resident A was returned back the facility with no negative outcome. 2. All residents have potential to be affected. QM was disciplined according to facility's progressive disciplines process and re-educated on facility's medication administration policy. 3. The facility's medication administration policy was reviewed and no changes and indicated at this time (see attachment). Licensed nurse and QMA's were re-educated the policy. The DON or her designee will randomly obseined medication administration 3 to weekly for 4 weeks, then one weekly for 4 weeks, then one month for 2 months, then quarterly thereafter (see attachment). 4. The findings these audits will be reviewed during the facility's quarterly Quality Assurance meetings the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before May 2011.	s:1. k to ve the A #1 the the the es d on rve cimes ce ce a of	05/22/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
111,2 12,111	or conduction	155468	A. BUI B. WIN	LDING IG		05/05/2	
NAME OF F	PROVIDER OR SUPPLIER		D. WII.	_	ADDRESS, CITY, STATE, ZIP CODE	ļ	
		& REHABILITATION		1	ST NORTHWOOD DR		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	AN, IN47882		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VIE.	DATE
		: Nurses are legally					
	responsible for						
	_	ive rights' of drug					
		Right patient.					
		ight dosage. Right					
	time. Right ro	oute."					
	TTI O 1:0 1	3 6 1° / 4° 1					
		Medication Aide					
		c Curriculum dated					
	October 2003	-					
	indicated, "Pri	•					
	_	Medications Six					
	Rights of Med						
	Administration						
		CATION. B. Give					
		OSE. C. Give the					
	medication to						
	RESIDENT. 1						
	_	the RIGHT ROUTE.					
		edication at the					
	_	. F. Enter the RIGHT					
	DOCUMENTATION in the chart."						
		linical record was					
	reviewed on M	1ay 05, 2011, at 10:45					
	a.m.						
	Dogidant Ala d	inanagag inaludad					
		iagnoses included,					
	but were not ii	mited to, arthritis,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155468		(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 00	li i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER	& REHABILITATION		325 WE	DDRESS, CITY, STATE, ZIP CODI ST NORTHWOOD DR AN, IN47882	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	atrial fibrillation	on, diabetes mellitus, e heart failure.					
	[evaluation of psychosocial h March 24, 201 A had short-te minutes] and l long past] mer Her cognitive daily decision severely impaid dependent on a decision making	red. She was nursing staff for daily ng.					
	dated March 2 co-signed by I indicated, "QN hall chg [charg Nurse #1] that Resident's med Resident [Resi [Resident A] ro Norvasc 5 mg	ident A]. Res. ec'd [received] i [one], ASA 81 mg i o 20 mg i [one], mg i [one],					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155468			(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	& REHABILITATION	325 WE	ADDRESS, CITY, STATE, ZIP CO EST NORTHWOOD DR /AN, IN47882	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	1 mg i [one], Net [and] K-dur @ this X [time [medications] Resident's [Refreceive]." Physician's ord lacked docume the physician I medications. Review of the Drug Handboo indicated: "Norvasc. Phe Calcium channed Therapeutic classification of the comparing the physician I medications." Review of the Drug Handboo indicated: "Norvasc. Phe Calcium channed the physician I medications and indicated: "Norvasc. Phe Calcium channed the physician I medicated: "Norvasc. Phe Calcium channed the physician I medications and indicated: "Norvasc. Phe Calcium channed the physician I medications and indicated: "Norvasc. Phe Calcium channed the physician I medications and indicated: "Norvasc. Phe Calcium channed the physician I medications and indicated: "Norvasc. Phe Calcium channed the physician I medications." Therapeutic classification in the physician I medication I medication in the physician I medicat	weren't this sident A] meds to recular for March 2011 entation to indicate had ordered the Nursing Spectrum ok, dated 2010, armacologic class: hel blocker. ass: ive. Indications and nitial hypertension, angina pectoris, and gina. Adverse indesired side effect sed by the of drugs]: CNS us system]: tiness, drowsiness,				
				I		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE S	ETED	
		155468	B. WIN			05/05/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BRECKE	NRIDGE HEALTH	& REHABILITATION		1	EST NORTHWOOD DR 'AN, IN47882		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION DATE
IAG	weakness, leth	· · · · · · · · · · · · · · · · · · ·		IAG	BEHELEKETY		DATE
		r]: peripheral edema					
	=	ssues contain an					
	-	unt of fluid], angina					
		pain or pressure in					
		ed by inadequate					
		d oxygenation to the					
		brady-cardia [a slow					
	_	ked by a pulse rate					
	below 60 beats						
		decrease in blood					
	"	oitations [a sensation					
	1 2 1	egular beating of the					
	_	stro-intestinal]:					
		ninal discomfort.					
		al: muscle cramps,					
		inflammation.					
	_	hortness of breath,					
		unger, resulting in					
		icult breathing],					
		in: rash, pruritus,					
	urticaria, flush	•					
	ĺ	-					
	"ASA. Pharm	acologic class:					
		inti-inflammatory					
	drug. Therape	•					
		algesic, antipyretic,					
		ig. Indications and					
	dosages: Mild	-					

Section Sect	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE COMPL		
NAME OF PROVIDER OR SUPPLER BRECKENRIDGE HEALTH & REHABILITATION ONLY DISCHMARY STRIBMINT OF DEFICIACIES (BACKLING) COMPLETION OR DESCRIPTION OF DESCRIPTION INTO REPORT OF DEVICE OF DE							
RECKENRIDGE HEALTH & REHABILITATION (NA) ID SUMMARY STATEMENT OF DETICINCIES PREPETY (REACH DETICINCY MIST BE PERCEDED BY FULL TAG REGULATORY OLD ISE DETICINCIES (REACH DETICINCY MIST BE PERCEDED BY FULL TAG REGULATORY OLD ISE DETICINCIES (REACH DETICINCY MIST BE PERCEDED BY FULL TAG REGULATORY OLD ISE DETICINCIES TAG REGULATORY OLD ISE DETICATION TO THE PREPETY OLD ISE DETICATION TO THE PROPERTY OLD ISE DETICATION. [VATION OLD INTERVAL OLD INTE	NAME OF F	PROVIDER OR SUPPLIER		 	ADDRESS, CITY, STATE, ZIP CODE	1	
SUMMARY STATEMENT OF DEFICIENCIES 1D PROCEED STAN OF CORRECTION COMPLETION				1			
REFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATIONS Adverse reactions: EENT [ears, eyes, nose, and throat]: hearing loss, tinnitus, ototoxicity [having a detrimental effect on the eighth nerve or the organs of hearing]. GI: nausea, vomiting, abdominal pain, dyspepsia [upper abdominal discomfort], epigastric distress, heartburn, anorexia, GI bleeding. Hematologic: thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decrease and hydration in the blood], hypokalemia [an					'AN, IN47882		
Adverse reactions: EENT [ears, eyes, nose, and throat]: hearing loss, tinnitus, ototoxicity [having a detrimental effect on the eighth nerve or the organs of hearing]. GI: nausea, vomiting, abdominal pain, dyspepsia [upper abdominal discomfort], epigastric distress, heartburn, anorexia, GI bleeding. Hematologic: thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an					(EACH CORRECTIVE ACTION SHOULD BE		
[ears, eyes, nose, and throat]: hearing loss, tinnitus, ototoxicity [having a detrimental effect on the eighth nerve or the organs of hearing]. GI: nausea, vomiting, abdominal pain, dyspepsia [upper abdominal discomfort], epigastric distress, heartburn, anorexia, GI bleeding. Hematologic: thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		`				ATE	
hearing loss, tinnitus, ototoxicity [having a detrimental effect on the eighth nerve or the organs of hearing]. GI: nausea, vomiting, abdominal pain, dyspepsia [upper abdominal discomfort], epigastric distress, heartburn, anorexia, GI bleeding. Hematologic: thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cells [ife span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		Adverse reacti	ons: EENT				
[having a detrimental effect on the eighth nerve or the organs of hearing]. GI: nausea, vomiting, abdominal pain, dyspepsia [upper abdominal discomfort], epigastric distress, heartburn, anorexia, GI bleeding. Hematologic: thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		[ears, eyes, no	se, and throat]:				
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distress, heartburn, anorexia, GI bleeding. Hematologic: thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		abdominal pair	n, dyspepsia [upper				
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thrombocytopenia [abnormal decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		distress, hearth	ourn, anorexia, GI				
decrease in the number of platelets/platelets enhance the coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		bleeding. Hen	natologic:				
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coagulation of blood], hemolytic anemia [destruction of red blood cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		decrease in the	e number of				
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cells resulting in a reduction in the mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		coagulation of	blood], hemolytic				
mass of circulating red blood cells], leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		anemia [destru	action of red blood				
leukopenia [abnormal decrease of white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		cells resulting	in a reduction in the				
white blood cells], agranulocytosis [a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		mass of circula	ating red blood cells],				
[a deficit or absolute lack of granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		leukopenia [ab	onormal decrease of				
granulocytic white blood cells], shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		white blood ce	ells], agranulocytosis				
shortened red blood cell life span. Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		[a deficit or ab	solute lack of				
Hepatic: hepatotoxicity. Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		granulocytic w	hite blood cells],				
Metabolic: hyponatremia [a decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		shortened red	blood cell life span.				
decreased concentration of sodium (the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		Hepatic: hepa	totoxicity.				
(the main contributor to osmotic pressure and hydration in the blood], hypokalemia [an		Metabolic: hy	rponatremia [a				
pressure and hydration in the blood], hypokalemia [an		decreased con-	centration of sodium				
blood], hypokalemia [an		(the main cont	ributor to osmotic				
		pressure and h	ydration in the				
abnormally low concentration of		blood], hypoka	alemia [an				
, i i i i i i i i i i i i i i i i i i i		abnormally lov	w concentration of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JH4N11

Facility ID: 000525

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPLE	ETED	
		155468	B. WING 05/05/2011				
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
While of TROVIDER OR SOTTELER				1	EST NORTHWOOD DR		
BRECKE	NRIDGE HEALTH	& REHABILITATION		SULLIV	'AN, IN47882		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE	
IAG	potassium (an			IAG			DAIL
	electrolyte) in	•					
		[an abnormally low					
	J 1 0 3	-					
	_	se (sugar/energy for					
		n) in the blood].					
		wheezing, hyperpnea					
	[increased resp						
	•	ema [a potentially					
		g accumulation of					
		ngs] with toxicity.					
	Skin: rash, ur	ticaria, bruising,					
	angioedema."						
	"Metoprolol.	Pharmacologic class:					
	Beta-adrenerg	ic blocker.					
	Therapeutic cl	ass:					
	Antihypertens	ive, antianginal.					
	Indications and	d dosages:					
	Hypertension	[high blood pressure].					
		ts: CNS: fatigue,					
		iety, depression,					
	· ·	wsiness, insomnia,					
	memory loss,						
	-	ousness, nightmares.					
	_	tic hypotension [low					
		e occurring when a					
	_	es an upright position					
	-	hair], peripheral					
		on [a decrease in the					
	vasoconstriction	on ta decrease in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155468			LDING	NSTRUCTION 00	(X3) DATE COMP 05/05/2	LETED	
NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION			P. W.	STREET A	DDRESS, CITY, STATE, ZIP CODE ST NORTHWOOD DR AN, IN47882	_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	diameter of blo extremities], be failure, pulmost blurred vision, nausea, vomitidiarrhea, flatul heartburn, dry Urinary frequest hepatitis. Met hyperglycemia Respiratory: we bronchospasm drug-induced la "Risperidal. P. Benzisoxazole Therapeutic cl. Indications and Schizophrenia CNS: aggress dizziness, drovextrapyramida rigidity, tremo increased drea periods, insome	ood vessels of the radycardia, heart hary edema. EENT: stuffy nose. GI: ng, constipation, lence, gastric pain, mouth. GU: ency. Hepatic: abolic: a, hypoglycemia. wheezing, . Skin: rash. Other: lupus syndrome." charmacologic class: derivative. ass: Antipsychotic. d dosage: . Adverse effects: ive behavior, wsiness, l reactions [muscular			CROSS-REFERENCED TO THE APPROF		
	•	esia [a neurologic ked by slow					

000525

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE : COMPL		
		155468	B. WIN			05/05/2	011
	PROVIDER OR SUPPLIER	& REHABILITATION		325 WE	ADDRESS, CITY, STATE, ZIP CODE EST NORTHWOOD DR 'AN, IN47882	1	
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	,, <u> </u>		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VIE.	DATE
	**	increased muscular					
]	kathisia [motor					
	restlessness], t	ransient ischemic					
	` ′′	cerebrovascular					
	accident (CVA	(a) [stroke],					
	neuroleptic ma	alignant syndrome [a					
		al syndrome]. CV:					
	orthostatic hyp	ootension, chest pain,					
	tachycardia [ai	n abnormal rapid					
	heart rate], arr	hythmias [irregular					
	rhythm of the	heart]. EENT:					
	vision disturba	ances, rhinitis,					
	sinusitis, phary	yngitis [inflammation					
	of the pharynx	(the passageway for					
	air from the na	asal cavity to the					
	larynx)]. GI:	nausea, vomiting,					
	diarrhea, const	tipation, abdominal					
	pain, dyspepsi	a, dry mouth,					
	increased saliv	vation, anorexia. GU:					
	difficulty urina	ating, polyuria					
	[excessive disc	charge of urine].					
	Musculoskelet	al: joint or back					
	pain. Respirat	ory: cough, dyspnea,					
	upper respirato	ory tract infection.					
	Skin: pruritus	, diaphoresis, rash,					
	dry skin. Othe	er: toothache, fever,					
	impaired temp	erature regulation."					
	"Benadryl. Ph	narmacologic class:					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	DING	00	COMPLI	URVEY ETED	
		155468	B. WIN			05/05/20)11
NAME OF PROVIDER OR SUPPLIER			•		ADDRESS, CITY, STATE, ZIP CODE		
BRECKENRIDGE HEALTH & REHABILITATION				1	EST NORTHWOOD DR 'AN, IN47882		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	7111, 11117002		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	thanolamine of	*					
		stamine receptor					
I	_	erapeutic class:					
A	ntihistamine,	antitussive,					
an	ntiemetic, ant	ivertigo agent,					
an	ntidyskinetic.	Indications and					
	•	gy symptoms caused					
by	y histamine re	elease, nausea,					
ve	ertigo. Adver	rse reactions:					
dr	owsiness, diz	zziness, headache,					
pa	aradoxical sti	mulation [seemingly					
co	ontradictory b	out demonstrably					
trı	ue]. CV: hyp	potension,					
pa	alpitations, ta	chycardia, EENT:					
bl	urred vision,	tinnitus. GI:					
di	arrhea, const	ipation, dry mouth.					
G ¹	U: dysuria, u	rinary frequency or					
re	tention. Skir	: photosensitivity.					
O	ther: decreas	ed appetite."					
	_	Pharmacologic class:					
Be	enzodiazepin	e. Therapeutic class:					
In	dications and	l dosages: Anxiety.					
A	dverse effects	s: CNS: amnesia,					
ag	gitation, ataxi	a [defective					
m	uscular coord	lination], depression,					
di	sorientation,	dizziness,					
dr	owsiness, he	adache,					
in	coordination,	asthenia [lack or					

000525

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	onstruction 00	(X3) DATE S COMPLE		
		155468	B. WIN		- 	05/05/20)11
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
BRECKE	NRIDGE HEALTH	& REHABILITATION		1	EST NORTHWOOD DR 'AN, IN47882		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	COMPLETION DATE
		h]. EENT: blurred					
	_	a [double vision],					
		voluntary movement					
	of the eyes]. (GI: nausea,					
	abdominal disc	comfort. Other:					
	increased or de	ecreased appetite."					
		Pharmacologic class:					
	_	nerapeutic class:					
	J 1 0 J	. Indications and					
	-	rove glycemic control					
		insulin-dependent)					
	diabetes mellit						
		diarrhea, nausea,					
	_	ominal bloating.					
		etic acidosis [an					
		acidity of blood due on of lactic acid].					
		sant metallic taste,					
	_	min B12 level."					
	decreased vital	111111 D12 10 VOI.					
	"K-dur. Pharn	nacologic class:					
		olyte. Therapeutic					
	class: Electrol	lyte replacement,					
	nutritional sup	plement. Indications					
	and dosages:	To prevent potassium					
	depletion. Ad	verse effects: CNS:					
	confusion, unu	isual fatigue,					
	restlessness, as	sthenia, flaccid					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2)]	MULTIPLE CO	NSTRUCTION		(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155468		JILDING	00		05/05/2	
		1.551.00	B. W		ADDRESS, CITY, STA	TE ZID CODE	33,00,2	
NAME OF I	PROVIDER OR SUPPLIER	1		1	ST NORTHWO	Ť		
BRECKE	NRIDGE HEALTH	& REHABILITATION		1	'AN, IN47882			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5)
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION DATE
	paralysis [loss	·						
	movement due	e to loss of muscle						
	tone], paresthe	esia [unpleasant						
	sensation ofter	n described at prickly,						
	stinging, or bu	ırning], absent						
	reflexes. CV:	ECG changes,						
	hypotension, a	arrhythmias, heart						
	block [interfer	rence with the normal						
		of electrical impulses						
	through the co	onduction system of						
	the heart], card	diac arrest. GI:						
	nausea, vomiti	ing, diarrhea,						
	abdominal disc	comfort, flatulence.						
	Metabolic: hy	perkalemia.						
	Musculoskelet	tal: weakness and						
	heaviness of le	egs. Respiratory:						
	respiratory par	ralysis."						
ı	Interview of I	icensed Nurse #1 on						
	May 05, 2011,							
		se #2 on May 05,						
		o.m., and the Director						
		May 05, 2011, at						
	_	icated on March 25,						
	2011, during th							
	-	ss, Q.M.A. #1 had						
	reported giving							
		nat had not been						
		ner. The medications						
FORM 5						10	. –	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	JH4N1	1 Facility 1	^{ID:} 000525	If continuation sh	neet Pa	ge 19 of 22

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155468	- 1	LDING	00	05/05/2	
		.00.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF PROVIDER OR SUPPLIER				1	EST NORTHWOOD DR		
	NRIDGE HEALTH	& REHABILITATION		1	'AN, IN47882		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
		p for another resident					
	and given to R	tesident A by mistake.					
	The medicatio	ns given were those					
	documented in	the Nurses Notes					
	dated March 2	5, 2011, at 9:18 a.m.					
	The Licensed	Nurses and Director					
	of Nursing fur	ther indicated this					
	was a medicat						
	On May 05, 20	011, at 2:55 p.m.,					
	Q.M.A. #1 wa	s interviewed.					
	During the inte	erview the Q.M.A.					
	indicated during	ng the morning					
	medication pas	ss she had two					
	residents' med	ications set up and					
		the medications					
	mixed up. The	e Q.M.A. had given					
	Resident A and	other resident's					
	medications, n	nedications not					
	•	her. The medications					
	given in error	were those					
	•	the Nurses Notes					
	dated March 2	5, 2011, at 9:18 a.m.					
	Resident A's N	Jurses Notes, dated					
	March 25, 201	1, indicated she had					
		local acute care					
	hospital for ev	aluation.					
	1						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUII		00		(X3) DATE COMPL	
		155468	B. WIN				05/05/2	011
	PROVIDER OR SUPPLIER	& REHABILITATION		325 WE	.DDRESS, CITY, STATE ST NORTHWOO AN, IN47882	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		Ē	(X5) COMPLETION DATE
		cute care hospital						
		nysical Report dated						
	March 25, 201	•						
	"HISTORY O							
		She is a resident of a						
		where she was						
	apparently giv							
	medications	. She was admitted						
	for further mor	nitoring and						
	management.	ASSESSMENT: A						
	91 year old wo	oman with						
	impression: 1]) Lethargy 2) Status						
	post administra	ation of multiple						
	medications (n	not intended for the						
	patient). 3) De	hydration 4) Anemia						
	5) History of h	ypertension 6)						
	Dizziness 7) A	Atrial fibrillation 8)						
	Diabetes melli	tus. PLAN: 1) The						
	patient is admi	itted for further						
	monitoring and	d management. 2)						
	Will continue	to monitor her vitals						
	as well as neur	rological status						
	closely. 3) Wi	ill also continue to						
	• •	y electrolytes and						
	EKG changes.	· ·						
	This federal ta	g relates to complaint						
	IN00088658.							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	_ JH4N11	Facility I	D: 000525	If continuation sl	neet Pa	L ge 21 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468	(X2) MULTIPLE CC A. BUILDING B. WING	00		E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	& REHABILITATION	325 WE	ADDRESS, CITY, STATE, ZIP C EST NORTHWOOD DR 'AN, IN47882		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3.1-48(c)(2)					